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ABSTRACT

Such drug education approaches as scare tactics have proved unsuccessful in the past, and a new educational model based on the health concept has been developed. The health concept model includes social, physical, mental and emotional growth and development, decision making, and interpersonal and intrapersonal interactions. Before applying the model, a basic understanding of human needs and types of drug use is needed. Meaningful learning experiences for working out drug use patterns should include goals with the following characteristics: they should be stated in terms of the learner; they should include cognitive, affective, and action domains; and they should identify the desired end results in terms that have clear meaning to the student. (SB)

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A CONCEPTUAL MODEL OF DRUG USE AND ITS IMPLICATIONS FOR SPECIAL EDUCATORS*

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Introduction

Within the last two decades the widespread use of illicit drugs has become a phenomenon of great impact upon America. Young people who may be classified as emotionally disturbed, socially maladjusted or disruptive youth are potential drug abusers. These young people are more vulnerable because of the nature of their exceptionality and therefore more apt to partake of the pleasures found in the use of recreational chemicals. Consequently, it behooves those who educate these young people to become familiar with the facts concerning drugs and to critique the methods which have been proposed as preventive measures to the whole sale use of drugs.

Educators have been asked to provide some magic solution, some fool-proof mechanism to prevent American youth from becoming enmeshed in the drug habit. Educators hoped to prevent drug abuse through the tool they know best, education. Those drug education programs that hold as their objective the prevention of all use of drugs are doomed before they start. The use of drugs will be with us for as long as one can predict. This fact becomes clear if one examines this nation's use of alcohol (one of the most damaging drugs available) or becomes aware of the millions of people, and not just young people, who smoke pot on a somewhat regular basis. What then should be the objectives of a drug education program and what can be included in such a program that might be successful?

Historically, drug education has not been an outstanding success. The use of illicit drugs was with us long before we as a nation panicked in the middle and late 60's. The fact that our clean cut white, middle class, American youth suddenly discovered the pleasures of being stoned, high, strung out or otherwise under the influence of chemicals greatly disturbed the American populace. We really did not mind too much if our sons and daughters stole a drink or two from the family liquor cabinet but we were horrified if we discovered a "joint" hidden in their bedrooms. The first widespread attempts at drug education reflected this national hysteria. Educators took the only

approach they knew at the time. They used scare tactics. The horrors of being a drug user were explicitly depicted in films, pamphlets and speeches. Little was known about the subject--fact and fiction were indiscriminently mixed. Young people found the discrepancies and soon learned to disbelieve adults. The situation deteriorated to such an extent that the federal government became aware of the misinformation being dispensed. A moritorium was called on the use of drug films in the Spring of 1973 as many of the films were poorly conceived and often contained information that was in direct conflict with the truth. In summary, the attempts at drug education using scare tactics were a dismal failure.

Educators, learning from their mistakes, became greatly concerned that the information they were dispersing was based on fact. They also began to include in their discussion examination of the socially acceptable drugs such as, alcohol and tobacco. The premise for this new approach was: "give them the facts and young people will make the right decisions." This premise was in error. Facts are presented in driver's education but it has not stopped drag racing. The detrimental effects of alcohol both physically and socially have been known for a good many years. But the rate of alcoholism is ever increasing as evidenced by the fact that in recent years more and more teenagers are becoming alcoholics.

It is obvious a different approach is needed. In an effort to gain a clearer perspective, individuals working in the area of drug education have been forced to re-evaluate their approach. From this re-evaluation it is suggested a more effective way to attack the problem is to deal with the total health status of the individual.

Health Concept

The concept of health status describes the condition of an individual as it reflects the degree of success one has in fulfilling his or her capacities (mental, physical, emotional, social) to the optimum. Each person is "measured" against a personalized barometer of health success ("how well I am doing with what I've got."). Utilizing this health concept requires a method of examining an individual's health status. Such a model will give the "helper" a tool to assist the individual and will give the individual a tool to help understand his capacities, the factors that influence them, and an opportunity to control those influences to his benefit.

FIGURE I

Health Status-Check Model

Ecological Interaction Among and Between		
Growth and Development	Decision Making	Interaction
1. Social 2. Physical 3. Mental 4 Emotional	Voluntary thru/to Involuntary	1. Interpersonal 2. Intrapersonal

The three major component of the model consist of growth and development, decision making, and interaction. These components have an ecological interaction with one another, as well as with the other model components. As an example, the physically disabled individual may react by not fulfilling his social or mental capacities. The same disability may also have influenced his past interaction and decision making patterns, and will likely exert similar influences in the future.

The first component of the model is the growth and development aspect. This aspect includes all the dimensions of growth and development (physical, mental, social, and emotional). The second component, interaction, deals with two major areas, interpersonal relations and intrapersonal relationships. The individual's entire perceptual field effects both the success he has in his relationships with other people and how he feels about himself. These forces are intimately tied to, and have influence on, the growth and development and the decision making components.

The final component of the Status-Check Model, decision- making, can be conceptualized as a continuum. It takes into account decisions that are made that are totally involuntary/ uncontrollable to those that are voluntary/controllable. Involuntary/uncontrollable decisions such as determining the function-rate of the pancreas and voluntary/controllable decisions such as choosing friends are examples of such a continuum of decision making. A clear understanding of the model requires examining the multitude of possible ecological interactions within the model and realizing the various routes such influences may take. Mental growth and development, for instance, does not always determine the amount or degree of success of interpersonal relationship. In fact, interpersonal relationships can influence mental growth and development and will certainly cause some changes

in the third component-- decision making. For example, below average mental growth and development may cause decreased opportunities for interpersonal relationships, that in turn leads to a feeling of rejection; or, "a feeling that people generally intend to hurt me, therefore I chose not to seek many interpersonal relationships".

Basic Human Needs

Given an understanding of how to determine "how well I'm doing with what I've got" and how to use the model to explore future events, the concept of human needs should be understood. All behavior is goal directed, that is individuals behave for a purpose, to satisfy needs. Understanding psychological needs are basic to understanding human motivation. Behavior is often predicated on the psychological need satisfaction important to that individual--in that time and space. Striving to satisfy such needs as love, recognition and status, independence, dominance, protection and dependency influences the choice of behavior in an individual's repertoire.

When one or more of these needs is thwarted a problem is encountered. The important point here is that the exceptional child has a greater chance to run into need satisfying dilemmas. He is more vulnerable. Unmet needs or needs met in socially unacceptable ways are many times

labeled as problems, and may manifest themselves as drug abuse, juvenile delinquency, or sexual promiscuity. The prospective offered here is that "problems," in reality, are only symptoms of unmet human needs or needs met in a socially unaccepted manner. These can take many different forms. We do not have any drug problems, we have people who have thwarted human needs who have turned to drugs to help them meet their needs. Sometimes the drug helps (insulin properly prescribed for diabetes) and sometimes it creates problems (alcohol taken in excess for relaxation). The vulnerable child has the same basic human needs as anyone else, but has a reduced capacity to satisfy them. This situation leaves them open to both self selected drugs and drugs selected by others to assist them. Such conditions, possibly, even probably increased the risk of drug abuse.

Types of Drug Use

The patterns of drug use need clarification. That is, we need to recognize that there are different kinds of drug use, before we can adequately deal with any symptoms. There are many schemes that could be utilized to describe patterns of drug use. The list that follows is only one configuration. It is however one that illustrates the complexity of the problem. Drug use can be divided into six different types:

(1) prescriptive,

(2) experimental,

(3) episodic,

(4) social/recreational,

(5) religious,

(6) compulsive.

This catagorization does not imply that drug use is strictly one or the other of the six types. Many times drug use is a combination of one or more of these catagories. For instance, young adults may experiment with alcohol in social/recreational situations in a very episodic pattern. It is not important here to describe the features of each category, but rather to point out that the last type, compulsive use, is the one that possesses most of the risks. All of the other types, however, can develop into complusive pattern. The main concern here, as before, is that the vulnerable individual is more susceptible to move from one of the five categories to the compulsive type user. The basis for such a theory is predicated upon the reduced capacity of the vulnerable individual to resist compulsive drug use.

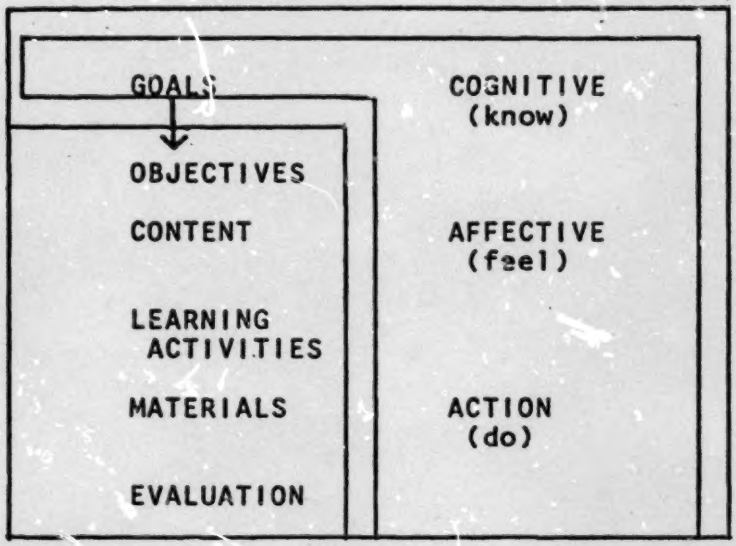
It is essential in our efforts to help vulnerable students help themselves that we do not put all types of drug use into one category. In fact, before any program encourages change in any type of drug use (recreational alcohol, prescriptive valium, complusive "speed") they ought to ask two questions. One, What is the "real" reason (need) the individual is using the drug? How do they know this? Two, Has the program that seeks change, helped the individual identify, understand, and use effective, alternative need-satisfying behaviors that are less risky than the current drug use pattern? Are they reasonably certain the individual will be successful with the alternative behaviors. Be careful of change for change sake and the oversimplification (apparent symptom reactions only) of human motives as they related to types of drug use.

Educational Approach

The value of an individualized concept of health, a workable status-check system for teachers and vulnerable children, and a useful basic human needs model, gives us a scheme through which drug use patterns can be investigated. What remains is the identification of methods to plan and conduct meaningful learning experiences for vulnerable children.

FIGURE II

Effective Planning Model



Meaningful learning experiences can be achieved by developing carefully conceived goal statements. This is the most difficult part of planning. Once usable goal statements have been developed and clarified they will serve as criteria for curriculum development. Goals should have the following characteristics: (1) they should be stated in terms of learner; (2) they should include cognitive, affective and action domains; (3) they should identify the desired end results in terms that have clear meaning to the student. Once this has been accomplished each goal can be broken down into the objectives necessary to attain the goals, appropriate content for each objective identified and meaningful learning activities created to facilitate the

acquisition of the particular content areas. Finally, materials can be selected to implement the learning activities developed and evaluation procedures established to determine whether or not progress toward program goals is being made. To start at any other point in the process reduces the chance for success. Programs based upon available materials, someone else's learning activities, what content the teacher knows best, or what tests are available are asking for problems.

Effective planning and teaching requires attention to all facets of learning. Many drug programs have focused solely on the cognitive aspects of education. Get the individual all the information, "facts", and he will feel and behave in a consistent manner. Noting the success of the alcohol and tobacco programs of the past, serves notice that this logic does not work.

At the moment many people are very "high" on affective education (value clarification, encounter groups, insight, etc.). Affective education, alone, has the same inherent difficulties as a program based solely on just information (cognition). A third aspect, action education (the doing, the application to life situations, the reality testing) has been avoided in many drug education programs for some obvious reason. Some "heretics" have suggested "teaching" students to drink alcohol in the classroom. It may mean the effective planning and teaching requires a heretic.

Especially when it involves the vulnerable child. The "heresy" involves planning toward helping the individual obtain information he or she can use and understand (cognitive), obtaining experiences that allow exploration of how I, and others, feel (affective) about such information, and experiencing activities that allow them to practice, apply, see, use, and/or demonstrate (action) their new found information and feelings. This model does not always follow this idealist sequence (Information = Feelings = Action). Some individuals start with the action first. The vulnerable child's action may begin with prescriptive drug use. He has no particular feelings about the drug, except the possible objections of swallowing a pill. Perhaps, he has no information about the drug except the fact that it is a yellow capsule. The point is, the individual begins to seek consonance between his action, his feelings, and what he knows. He will start with his perceptions, right or wrong or inbetween and build toward continuity.

This need to achieve consonance can be utilized effectively in planning and conducting drug programs for vulnerable individuals. After needs are accessed the program can begin "where the student is at." If the program includes all of these components (cognitive, affective and action) it will greatly reduce the dissonance, inconsistancy, and fragmentation that plague so many drug education programs. This is particularly true for the vulnerable child, who has an additional built-in risk allowance.